NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
2005 PERSONAL CARE SERVICE COST REPORT

Report Due Date: July 28, 2006

SCHEDULE A

Part I - General

1. Tax ID#:	2a. Medicaid Provider Number:

2b. Name of Agency:
Street or P.O.
City, State, Zip Code
Agency Telephone No.:
3. County Name Agency Resides In
4. Owner (s)
5. Contact Person, if different from above
6. Contact Telephone Number
7. Date Agency began in PCS business:

Part II - Tax Information

8a. Non Profit	8b. For Profit	
[ ] 1. Private	[ ] 3. Sole proprietorship	[ ] 5. Partnership
[ ] 2. Other _____	[ ] 4. Corporation	[ ] 6. Other _____

Part III - Other Reporting Information

9. Cost Report Period: From:	To:

10. Type of accounting method used: [ ] CASH [ ] ACCRUAL

11. Basis of allocating costs within cost report, if you provide more than personal care services:

Part IV - Certification of Accuracy

I hereby attest that I have examined the information contined in this report; that all such information has been prepared from the books records of the provider named within; that the aforesaid iformation is true and correct to the best of my knowledge; that our agency has on file and proper client authorization for these services and the necessary documentation to support these costs, and that all costs reported period are within the indicated above.

Provider's Signature	Title:	Date
Preparer's Name	Title:	Date
Preparer's Telephone Number:	Preparer's Email Address:	Preparer's Fax Number:

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

2005 PERSONAL CARE SERVICE COST REPORT

SCHEDULE OF GENERAL INFORMATION - CONTINUED — SCHEDULE A-1

NAME: (Schedule A: item 1)	Tax ID#
0	0

MEDICAID PROVIDER #: (Schedule A: item 1)

#VALUE!

	NAME	MEDICAID PROVIDER #	AGENCY ADDRESS	COUNTY
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

2005 PERSONAL CARE SERVICE COST REPORT

SCHEDULE OF PROFIT AND LOSS		**SCHEDULE B**
NAME: (Schedule B: item 1) **#VALUE!**		**Tax ID#** ='Sch A'!A9:H9
MEDICAID PROVIDER #: (Schedule B: item 1) **#VALUE!**		
Cost Report Period: **From:**	**To:**	
REVENUES:	1	2
RECEIPTS FROM THE MEDICAID		
1. MEDICAID PERSONAL CARE SERVICE		
2. MEDICAID CAP-DA In Home Aide II & III PCS		
3. OTHER:		
4.		
5.		
6. TOTAL RECEIPTS FROM MEDICAID (Add lines 1-5)		$ -
RECEIPTS FROM OTHER STATE AGENCIES OR THE COUNTY		
7.		
8		
9		
10. TOTAL RECEIPTS FROM OTHER STATE/COUNTY SOURCES (Add lines 7, 8, and 9)		$ -
RECEIPTS FROM PRIVATE CLIENTS		
11. PRIVATE PAY RECEIPTS		
12.		
13.		
14. TOTAL RECEIPTS FROM PRIVATE CLIENTS (Add lines 11, 12 and 13)		$ -
NON-CLIENT RELATED REVENUE		
15. RECEIPTS FROM OTHER SOURCES		
16.		
17. TOTAL NON-CLIENT RELATED REVENUES (Add Lines 15 and 16)		$ -
18. TOTAL INCOME REPORTED (Add Lines 6, 10, 14, and 17)		$ -
19. LESS: TOTAL EXPENSES (Value should equal Schedule C, Line 98, Column 3)		
20. NET PROFIT (LOSS) (Subtract Line 19 from Line 18)		$ -

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

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SCHEDULE OF EXPENSES — SCHEDULE C

Agency Name: 0	Tax ID# 0			
Agency Medicaid number: #VALUE!				
Cost Report Period: From:	To:	HOURS FOR PAID STAFF / OWNERS	HOURS FOR UNPAID OWNERS/ OPERATORS/ VOLUNTEERS	EXPENSES
Direct Cost Centers		1	2	3
PERSONAL CARE EXPENSES WITHIN MEDICAID SERVICE DEFINITION				
30. Salaries and Wages for Nurses				
31. Payroll Taxes				
32. Employee Benefit Program				
33. Training Costs				
34. Travel Costs				
35. Contract Services				
36. Transportation costs associated with providing Personal Care Services				
37. Other Direct costs (please list)				
38. ***SUBTOTAL OF NURSE PERSONAL CARE COSTS*** (Add lines 30-37)		0.00	0.00	$ -
39. Salaries and Wages for Aides				
40. Payroll Taxes				
41. Employee Benefit Program				
42. Training Costs				
43. Travel Costs				
44. Contract Services				
45. Transportation costs associated with providing Personal Care Services				
46. Other Direct costs (please list)				
47. ***SUBTOTAL OF AIDE PERSONAL CARE COSTS*** (Add lines 39-46)		0.00	0.00	$ -
48. Salaries and Wages for All Others				
49. Payroll Taxes				
50. Employee Benefit Program				
51. Training Costs				
52. Travel Costs				
53. Contract Services				
54. Transportation costs associated with providing Personal Care Services				
55. Other Direct costs (please list)				
56. ***SUBTOTAL OF ALL OTHER DIRECT PERSONAL CARE COSTS***		0.00	0.00	$ -
57. TOTAL OF ALL PERSONAL CARE COSTS WITHIN MEDICAID DEFINITION (Add lines 38, 47, and 56) (Hours in Column 1 and 2 and Expenses in		0.00	0.00	$ -
PERSONAL CARE EXPENSES OUTSIDE THE MEDICAID SERVICE DEFINITION				
58. Salaries and Wages for Nurses				
59. Salaries and Wages for Aides				
60. Salaries and Wages for All Others				
61. Payroll Taxes				
62. Employee Benefit Program				
63. Contract Services				
64. Miscellaneous				
65. TOTAL OF ALL PERSONAL CARE COSTS OUTSIDE THE MEDICAID DEFINITION (Add lines 58 - 64) (Hours in Column 1 and 2 and Expenses in Column 3)		0.00	0.00	$ -

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
2005 PERSONAL CARE SERVICE COST REPORT

SCHEDULE OF EXPENSES continued **SCHEDULE C**

Agency Name: 0	**Tax ID#** 0			
Agency Medicaid number: #VALUE! 0				
Cost Report Period: **From:** **To:**		HOURS FOR PAID STAFF / OWNERS	HOURS FOR UNPAID OWNERS/ OPERATORS/ VOLUNTEERS	EXPENSES
Indirect Cost Centers		1	2	3
ADMINISTRATION & GENERAL				
66. Salaries and Wages - Administrator(s)/Owner(s)				
67. Salaries and Wages - Other Support staff				
68. Payroll Taxes				
69. Employee Benefit Program				
70. Meetings / Seminars / Training				
71. Travel Costs				
72. Contract Services		0.00		
73. Employee Criminal Records Check Fees				
74. Management Services				
75. Central Office Overhead				
76. Other Administrative expenses				
77. TOTAL OF ADMINISTRATION & GENERAL (Add Lines 66-76)(Columns 1, 2 & 3)		0.00	0.00	$ -
OPERATIONS / MAINTENANCE				
78. Salaries and Wages				
79. Payroll Taxes				
80. Employee Benefit Program				
81. Contract Services		0.00		
82. Supplies				
83. Other Operatoins/Maintenance expenses				
84. TOTAL OF OPERATIONS / MAINTENANCE (Add lines 78-83) (Columns 1, 2 & 3)		0.00	0.00	$ -
Capital Cost Center				
PROPERTY / OWNERSHIP / USE				
85. Depreciation				
86. Rent for Facility				
87. Other Capital expenses				
88. TOTAL OF PROPERTY / OWNERSHIP / USE: CAPITAL COST CENTER (Add Lines 85-87) Expenses in column 3)				$ -
Non-Allowable Cost Center				
NON-ALLOWABLE				
89. Bad Debt				
90. Marketing to increase business				
91. Other related party transactions				
92. Miscelleous				
93. TOTAL OF NON-REIMBURSABLE (Add lines 89-92)				$ -

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
2005 PERSONAL CARE SERVICE COST REPORT

SCHEDULE OF EXPENSES continued — SCHEDULE C

Agency Name: 0	**Tax ID#** 0			
Agency Medicaid number: #VALUE!		**HOURS FOR PAID STAFF / OWNERS**	**HOURS FOR UNPAID OWNERS/ OPERATORS/ VOLUNTEERS**	**EXPENSES**
0				
Cost Report Period: **From:**	**To:**			
Summary of Cost Center Totals		1	2	3
94. TOTAL OF DIRECT COST CENTERS (Add Lines 57, 65) (Hours in Column 1 and 2 and Expenses in Column 3)		**0.00**	**0.00**	**0.00**
95. TOTAL OF INDIRECT COST CENTERS (Add Lines 77, 84) (Hours in Column 1 and 2 and Expenses in Column 3)		**0.00**	**0.00**	**$0**
96. TOTAL OF CAPITAL COST CENTERS (Add Line 88) (Expenses in Column 3)				**$0**
97. TOTAL OF NON-ALLOWABLE COST CENTERS (Add Line 93) (Expenses in Column 3)				**$0**
98. TOTAL OF ALL COST CENTERS (Add Lines 94, 95, 96, 97) (Hours in Column 1 and 2 and Expenses in Column 3)		**0.00**	**0.00**	**$0**
99. TOTAL OF ALL ALLOWABLE COSTS (Add Lines 57, 95, 96) (Hours in Column 1 & 2 & Expenses in Columns 3)		**0.00**	**0.00**	**$0**
100 TOTAL BILLED HOURS (enter figure here)				
101 AVERAGE COST PER BILLED HOUR (Line 99 divided by Line 100)				**#DIV/0!**

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
2005 PERSONAL CARE SERVICE COST REPORT

BASIS OF ALLOCATING EXPENSES BETWEEN PERSONAL CARE SERVICES AND OTHER AGENCY SERVICES - SCHEDULE D

AGENCY NAME:			**Tax ID#** **0**
#VALUE!			**0**
MEDICAID PROVIDER #: (Schedule D: item 1) **0**			**Cost Report Period - From - To**
Description of Line Item (Expense/Cost)	**Line item**	**Direct Charged or Allocated**	**Basis of Allocation**
Salaries and Wages			
Payroll Taxes			
Employee Benefit Program			
Contract Services			
Rent - Facility			